

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PEND "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 19234

1. DECEASED NAME (TYPE OR PRINT)			FIRST Nichole			MIDDLE Nichole			LAST Carter			2a. DATE OF DEATH 7-3-82			KNOWN MONTH DAY YEAR 7-3-1982			2b. HOUR 6:25 AM					
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 3-19-73			6. AGE (IN YEARS LAST BIRTHDAY) 9 YRS.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN			9. DATE PRONOUNCED DEAD 7-3-82			10. DATE MONTH DAY YEAR 7-3-1982		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alexandra, Va.			11. CITIZEN OF WHAT COUNTRY? USA			12. MARRIED WIDOWED			13. NEVER MARRIED DIVORCED			14. BALTIMORE CITY OR COUNTY OF DEATH Somerset			15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY					
17. CITY OR TOWN OF DEATH Crisfield			18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION McCrady Hospital			19. CITY OR TOWN Manassas			20. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Manassas			21. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			22. STREET ADDRESS Breckland Road			23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min					
24. FATHER'S NAME Carter			25. MIDDLE G.			26. LAST Marshall			27. MOTHER'S MAIDEN NAME Gloria			28. ADDRESS Woodson			29. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 9108 IMMEDIATE CAUSE (a) Accidental drowning Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
30. DATE OF OPERATION			31. CONDITION FOR WHICH OPERATION WAS PERFORMED?			32. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
33. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
36. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			37. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			38. LOCATION STREET			39. CITY OR TOWN			40. COUNTY			41. STATE								
42. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															43. TITLE (SPECIFY) James A. Sterling, M.D.								
44. EXAMINER'S NAME (TYPE OR PRINT) James A. Sterling, M.D.															45. MEDICAL EXAMINER James A. Sterling, M.D.			46. DATE SIGNED 7-3-82					
47. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			48. DATE			49. NAME OF CEMETERY OR CREMATORIAL OAK GROVE			50. LOCATION CITY OR TOWN MIDLAND			51. COUNTY FAIRFAX			52. STATE VA.								
53. FUNERAL DIRECTOR NAME Hortaylor, Edward C. C. M.			54. ADDRESS			55. DATE REC'D. BY REGISTRAR JUL 13 1982			56. REGISTERED NUMBER 1000														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PIM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 19235	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN MONTH DAY YEAR		2b. HOUR			
		HENRY GILES						7. 13 1982		M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN			
MALE		C.		1/14/33		49 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		10. BALTIMORE CITY OR COUNTY OF DEATH	
FLA.		U.S.A.										SOMERSET	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTOVER		LABOR CAMP						LABOR		MD			
13. PREVIOUS RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13. STATE		13. COUNTY		13. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
FLA.		FLA.		FLA.		FLA.							
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		LAST			
NOT KNOWN								NOT KNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		ADDRESS			
NO		?						STATE POLICE		PRINCESS ANNE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5713</i> <i>Gastrointestinal bleeding</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Alcoholic liver disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>C. Regna</i>		TITLE (SPECIFY) M.D.						MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)								ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/27/82</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>MC. PEER CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>MARION, MD.</i>		COUNTY		STATE			
24. FUNERAL DIRECTOR <i>WILSON FUNERAL HOME</i>		ADDRESS <i>PRINCESS ANNE, MD.</i>						25a. DATE REC'D. BY REGISTRAR <i>J. A. G. Conard</i>		25b. REGISTRAR			
DMMH-17 (VR A15 ME (5)) 15M 2/80								AUG 11 1982					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
retdned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	1	9	2	3	6
1 - STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR	
Edith S. Marshall									7-20-82						11:00aM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Oct. DAY 27 YEAR 1892			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
									89			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Somerset			MD.				
10. CITY OR TOWN OF DEATH Crisfield			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCready Mem. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland			13b. COUNTY Somerset			13c. CITY OR TOWN Crisfield			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Asbury Ave.				
14. FATHER'S NAME FIRST Edward			MIDDLE			LAST Wilson			15. MOTHER'S MAIDEN NAME FIRST Olethia			MIDDLE LAST Somers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-14-9265			17. INFORMANT George T. Marshall Jr.			ADDRESS 29 Asbury Ave. Crisfield, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5325										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Perforated duodenal ulcer																
19a. DATE OF OPERATION 7-7-82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Duodenal Ulcer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Perforated Duodenal Ulcer										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>7-20-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 0-21-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Sterling			22e. ADDRESS Main St., Crisfield, Md. 21817			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 22, 82			23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge			23d. LOCATION Crisfield			25a. DATE REC'D. BY REGISTRAR 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Wathen		
24. FUNERAL DIRECTOR NAME Hinman's Funeral Home, Crisfield, Md. 21817			ADDRESS													
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 19237	
1- FOR STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH 7 MONTH 7 OF ESTI- DAY 25 DAY 25 DEATH MATED 1982 YEAR 1982									2b. HOUR 4A M	
1. DECEASED NAME (TYPE OR PRINT) <b>Georgie McIntosh</b>			MIDDLE <b>Pittman</b>			LAST			2c. DATE PRONOUNCED DEAD 7 25 1982			2d. HOUR 11:40 M	
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>6</b> YEAR <b>1927</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>54 yrs.</b>	7. IF UNDER 1 YR. MONTHS <b>0</b>	8. IF UNDER 24 HRS. DAYS <b>0</b>	9. HOURS <b>0</b>	10. MIN. <b>0</b>	2e. DATE PRONOUNCED DEAD 7 25 1982			2d. HOUR 11:40 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>X</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Somerset</b>			MD		
10. CITY OR TOWN OF DEATH <b>Pocomoke</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>At Home Rehobeth Rd. Pocomoke</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>				
13a. STATE <b>Md.</b>	13b. COUNTY <b>Somerset</b>	13c. CITY OR TOWN <b>Pocomoke</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>R.F.D. #1 Box 113B.</b>							
14. FATHER'S NAME FIRST <b>James Fisher</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			17. INFORMANT ADDRESS <b>Fosque P.O. Box 272 James Fisher Sr. Waughopreague, Va.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <b>CVH</b>			19. DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD, HTN &amp; Diabetes Mellitus</b>			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>							
21a. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST. <b>4292</b>			21b. DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD, HTN &amp; Diabetes Mellitus</b>			21c. (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. T9			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
22b. TITLE (SPECIFY) <b>James A. Stalling</b> M.D. MEDICAL EXAMINER													
23a. EXAMINER'S NAME (TYPE OR PRINT) <b>James A. Stalling</b>													
23b. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/31/82</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Christ Cem.</b>			23d. LOCATION CITY OR TOWN <b>Pocomoke, Somerset, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Samuel Saylor</b>			24. ADDRESS <b>New Church Va.</b>			25. DATE REC'D BY BURIAL OR TRANSPORT REGISTER'S SIGNATURE <b>JUL 30 1982</b>							
DHMH - 17 (VR A15 ME (5)) 20M 4/82													

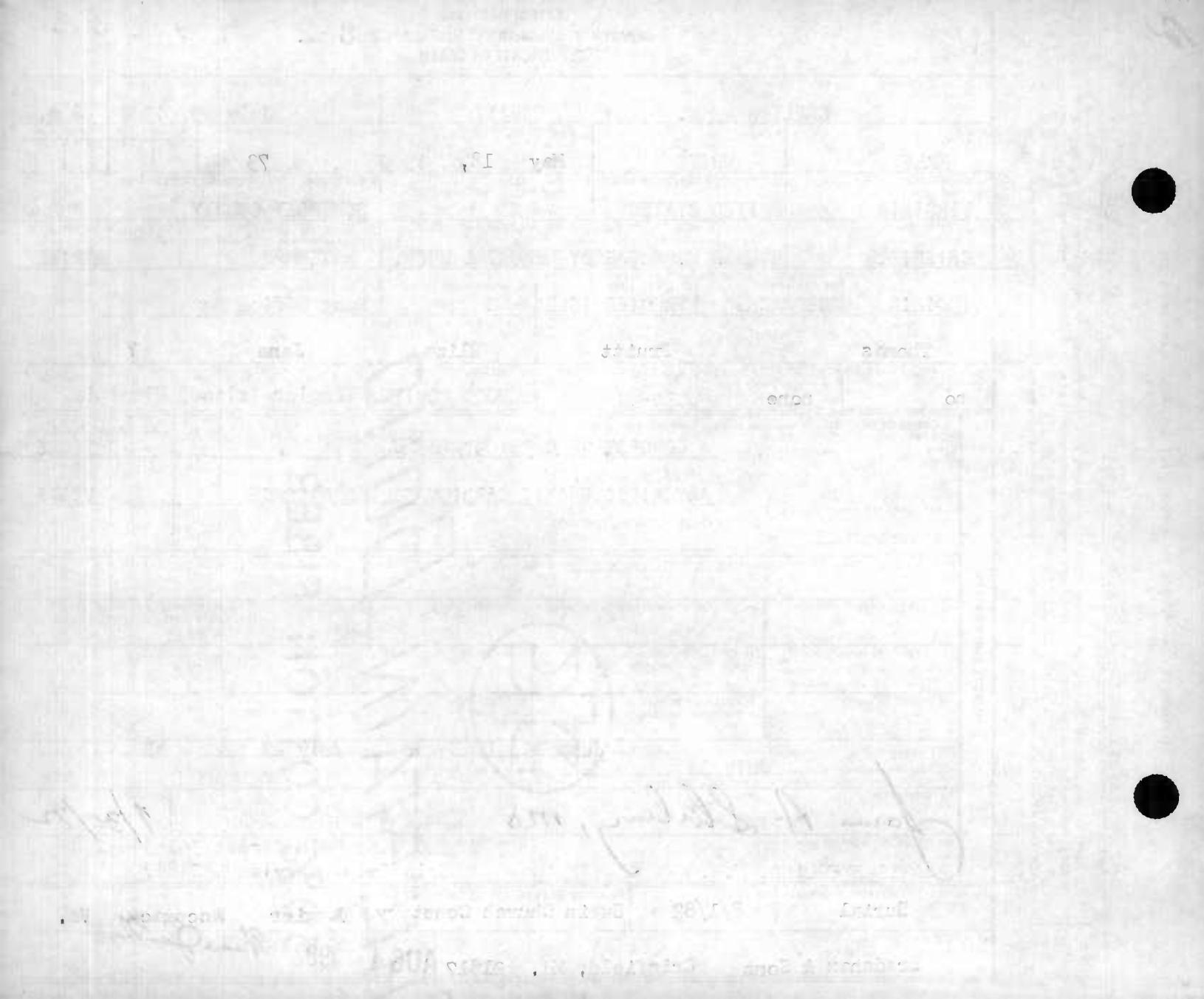


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	9	2	3	8
1 - FOR STATE REGISTRAR			REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
CARLTON W. PRUITT						July 29, 1982						6 a. m.						
3. SEX			4. RACE		5. DATE OF BIRTH			16. AGE (IN YEARS LAST BIRTHDAY)			17. IF UNDER 1 YEAR MONTHS DAYS			18. IF UNDER 24 HRS. HOURS MIN.				
MALE			WHITE		MONTH DAY YEAR			May 18, 1909			73 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
VIRGINIA			UNITED STATES					SOMERSET COUNTY, MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
CRISFIELD			EDWARD W. McCREADY MEMORIAL HOSP.		WATERMAN			MARINE										
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
VIRGINIA			ACCOMACK		TANGIER ISLE						Post Office Box							
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST									
Thomas				Pruitt	Eliza			Jane										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			23440							
no			none		230-42-7423			ELWOOD PRUITT: Tangier Island, Virginia,										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE CARDIOMYOPATHY															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS			
4254 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE															YEARS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 29, 1982 to July 29, 1982, that (I) (we) last saw the deceased alive on July 28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED 7/30/82			
22b. SIGNATURE James A. Sterling, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS						320 West Main Street/301-968-1949									
JAMES STERLING, M.D.									Crisfield, Maryland, 21817									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/1/82			23c. NAME OF CEMETERY OR CREMATORIAL Swain Church Cemetery			23d. LOCATION CITY OR TOWN Tangier			COUNTY Accomack			STATE Va.			
24. FUNERAL DIRECTOR NAME Bradshaw & Sons			ADDRESS Crisfield, Md. 21817						25a. DATE REC'D. BY REGISTRAR AUG 4 1982			25b. REGISTRATION NO.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
William Byers Stein												July 17, 1982						2:30 P.M.								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS											
Male			White			MONTH DAY YEAR Jan. 24, 1908			74			MONTHS DAYS			HOURS MIN											
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Indiana			U.S.						Somerset			Princess Anne			Route 1											
13a. STATE Maryland												13b. COUNTY Somerset			13c. CITY OR TOWN Princess Anne			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Route 1					
14. FATHER'S NAME FIRST William			MIDDLE James			LAST Stein			15. MOTHER'S MAIDEN NAME FIRST Cydie			MIDDLE Belle			LAST Byers											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arrest of the heart</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
1629												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</i>														
												DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1981</i> to <i>July 17, 1982</i> , that (I) (we) last saw the deceased alive on <i>July 15, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE <i>David E. Howell MD</i>												DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>7/18/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPEC#)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL LAW			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
Cremation			7/19/82			Delmarva Crematory			Lewes			Delaware			Salisbury			MD								
24. FUNERAL DIRECTOR NAME James L. Hinman			ADDRESS			25a. DATE REC'D. BY REGISTRY OR 25b. REGISTRAR'S SIGNATURE			25c. DATE REC'D. BY REGISTRY OR 25d. REGISTRAR'S SIGNATURE			25e. DATE REC'D. BY REGISTRY OR 25f. REGISTRAR'S SIGNATURE			25g. DATE REC'D. BY REGISTRY OR 25h. REGISTRAR'S SIGNATURE			25i. DATE REC'D. BY REGISTRY OR 25j. REGISTRAR'S SIGNATURE								
Princess Anne						JUL 21 1982																				

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## Introduction and outline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	9	2	4	0
												REG. NO.						
1	FOR STATE REGISTRAR																	
1a	DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR						
	Janie		M		Tyler	7			18	82		5:15am						
3	SEX		4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)							
	Female		White		10 09 79						103 YRS							
7b	BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
	Maryland		USA								Somerset MD							
10	CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
	Crisfield		Alice Byrd Tawes Nursing Home			Housewife			- - -									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a	STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS											
	Maryland	Somerset	Smith Island	NO <input type="checkbox"/>			Ewell, Smith Island											
14	FATHER'S NAME FIRST		MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST									
	Filmore			Evans	Mary					Williams								
16a	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS										
	No		218-12-7104		Norman Tyler, Smith Island, MD													
II CAUSE OF DEATH (Enter only one cause per line for 18a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z)												AGE AT DEATH BETWEEN ONSET AND DEATH						
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a)												4292 HSCVD						
DUE TO, OR AS A CONSEQUENCE OF (b)												Hypertension						
Conditions, if any, which gave rise to the immediate cause (1a), stating the underlying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a	19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d	21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a	22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 07-14-82 and that in my (our) opinion death occurred at the date and hour and from the causes stated above. (1b) (we) did not see the body after death.												19 79 to 19 82 that (1) (we) lost					
22b	22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN			22e. MEDICAL DIRECTOR			22f. STAFF PHYSICIAN			22g. DATE SIGNED			
	James A. Sterling, MD														07/21/82			
22d	22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ATTENDING PHYSICIAN			22g. MEDICAL DIRECTOR			22h. STAFF PHYSICIAN			22i. DATE SIGNED			
	James A. Sterling, MD		320 Main St. - Crisfield, MD 21817												07/21/82			
23a	23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Ewell Church Cemetery			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
	Burial		7/20/82						Ewell			Somerset		Md.				
24	24 FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
	Bradshaw & Sons		Crisfield, Md. 21817			JUL 23 1982												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For  
retd by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be  
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of issue  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 310-732-3500.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 9 2 4 1					
										REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST				7-18-82		10:15pm			
Katie Waters			M.			Waters									
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH 12 DAY 10 YEAR 05				6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Somerset		MD.			
10. CITY OR TOWN OF DEATH Crisfield			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Alice Byrd Tawes Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer				12b. KIND OF BUSINESS OR INDUSTRY Food Process					
13a. STATE Md.			13b. COUNTY Worcester			13c. CITY OR TOWN Unionville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 330, Unionville			
14. FATHER'S NAME FIRST: Lev MIDDLE: M. LAST: Wilson			15. MOTHER'S MAIDEN NAME FIRST: unknown MIDDLE: Susie LAST: P												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-07-0428			17. INFORMANT ADDRESS Leroy Waters, Pocomoke, MD									
18. CAUSE OF DEATH (Enter only one cause per line for item 18, PART 1) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4292										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Septicemia</i> (c) <i>multiple Sarcobacter ulcers</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/29/82</i> to <i>1/29/82</i> , 19 <i>82</i> , to <i>1/18/82</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1/26/82</i> , 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (I) did not see the body after death, check here) <input type="checkbox"/>															
22b. SIGNATURE <i>James A. Sterling, MD</i>										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. DATE SIGNED <i>5/2/82</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Sterling, MD			22f. ADDRESS 320 Main St. - Crisfield, MD 21817												
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 7-24-82			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Cem.				23d. LOCATION CITY OR TOWN Pocomoke, Md.		23e. COUNTY Wicomico Co., Md.			
24. FUNERAL DIRECTOR Name <i>James Sneed</i>			24a. DATE REGD. IN PROSTRADE JUL 30 1982							24b. SIGNATURE					
24c. ADDRESS New Church, Va.															

